

MISSOURI DIVISION OF HEALTH - STANDARD CERTIFICATE OF DEATH

DEPARTMENT OF PUBLIC HEALTH AND WELFARE

-62-001385

STATE FILE NUMBER

AMENDED

Registration District No.

139

Primary Registration District No.

Registrar's No.

11

FILED FEB 14 1962

1. PLACE OF DEATH

a. COUNTY

HOLT

2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission)

a. STATE

Missouri

b. COUNTY

HOLT

Inside Limits

Yes ☒ No ☐b. CITY (If outside corporate limits, give TOWNSHIP only)
OR
TOWN

OREGON

Length of stay in 1b

2 YRS

c. CITY
OR
TOWN

Mound City

c. FULL NAME OF (If NOT in hospital, give location)
HOSPITAL OR
INSTITUTION

BROWNE NURSING HOME

Inside Limits

Yes ☐ No ☐d. STREET
ADDRESS

(If outside, give location)

Reside on Farm

Yes ☐ No ☒3. NAME OF DECEASED
(Type or print)

First

Middle

Last

JOHN BURL CHUNING

4. DATE
OF
DEATH

Month

Day

Year

JAN. 28, 1962

5. SEX

MALE

6. COLOR OR RACE

WHITE

7. Married ☐ Never Married ☐Widowed ☐ Divorced ☒

8. DATE OF BIRTH

5-9-1892

9. AGE (last birthday)

69

IF UNDER 1 YEAR

IF UNDER 24 HR

Months

Days

Hours

Min.

10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)

LABORER

10b. KIND OF BUSINESS OR INDUSTRY

COMMON LABOR

11. BIRTHPLACE (City and state or country)

Bigelow, Mo.

12. CITIZEN OF WHAT COUNTRY

U.S.A.

13a. FATHER'S NAME

CHARLES CHUNING

13b. MOTHER'S MAIDEN NAME

JESSIE

14. NAME OF HUSBAND OR WIFE

-

15. WAS DECEASED EVER IN U.S. ARMED FORCES?

(Yes, no, or unknown) (If yes, give war or dates of service)

No

16. SOCIAL SECURITY NO.

17. INFORMANT

Address

HOLT COUNTY WELFARE. Mound City, Mo.

18. CAUSE OF DEATH (Enter only one cause per line for PART I. DEATH WAS CAUSED BY:

IMMEDIATE CAUSE (a)

Cerebral Hemorrhage

INTERVAL BETWEEN ONSET AND DEATH

3 days

Conditions, if any, which gave rise to above cause (a), stating the underlying cause last.

DUE TO (b)

cerebral hemorrhage

Jan '60.

DUE TO (c)

PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH but not related to the terminal disease condition given in PART I (a)

PART III. If deceased was female was there a pregnancy in last 90 days.

☐ Yes ☐ No ☐ Unknown19. WAS AUTOPSY PERFORMED?
YES ☐ NO ☒

20a. ACCIDENT

☐

SUICIDE

☐

HOMICIDE

☐

20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in PART I or PART II of item 18.)

20c. TIME OF INJURY

Hour

a.m.

Month, Day, Year

p.m.

20d. INJURY OCCURRED WHILE AT WORK ☐ NOT WHILE AT WORK ☐

20e. PLACE OF INJURY (e.g., in or about home, farm, factory, street, office bldg., etc.)

20f. CITY, TOWN, OR LOCATION

COUNTY

STATE

21. I attended the deceased from Jan 60, to Jan 28 and last saw her alive on Jan 29, 61

Death occurred at 8:30 A. m on the date stated above, and to the best of my knowledge, from the causes stated.

22a. SIGNATURE

(Degree or title)

Dr H. E. Coburn D.O.

22b. ADDRESS

Oregon Mo.

22c. DATE SIGNED

2-3-62

23a. BURIAL, CREMATION, REMOVAL (Specify)

BURIAL

23b. DATE

1-31-1962

23c. NAME OF CEMETERY OR CREMATORY

Mound City Cem.

23d. LOCATION (City, town, or county)

Mound City, Mo.

(State)

24. FUNERAL DIRECTOR

ADDRESS

James H. Crawford, Mound City, Mo.

25. DATE RECD. BY LOCAL REG.

2-3-1962

26. REGISTRAR'S SIGNATURE

James H. Crawford

(Licensed Embalmer's Statement on Reverse Side)

DATE AMENDED

INSTEAD OF

SHOULD READ

ITEM NO.

DOCUMENT

MEDICAL CERTIFICATION

BY AFFIDAVIT OF

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me,
or by _____, Student Embalmer No. _____
working under my personal supervision.

Student _____
Signature of Student Embalmer

Signed James H. Crawford

Licensed Embalmer No. 4796

P. O. Address Mound City, Mo.

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license).

If embalmed by a STUDENT, he also shall sign in his OWN handwriting.

If this body is not embalmed, fact should be so stated above.